HFA MEMBERSHIP DONATION FORM

Membership Level

I wish to join: (circle one)

$25 (Individual) $50 (Family) $100 (Industry Professional) $500 (Corporate) Other $ ________

Personal Information:

Name ________________________________ Address ____

City ___________________________________ State ______________________ Zip __________________

Telephone __________________________ E-Mail Address _______________________________________

Payment:

I would like to make my gift by:

☐ Check (Please make payable to Hemophilia Federation of America)

Mail check and accompanying form to: Hemophilia Federation of America

210 7th St. SE Suite 200B
Washington, DC 20003

☐ Credit Card: (Donations under $2,000)

Visa _________ MasterCard _________ American Express _________ Discover __________

Card Number ___________________________________ Expiration Date ___________________________

Name on Card _____________________________________ Security Code __________________________

Signature ____

If you are making an Honorary or Memorial Gift: (Please circle your preference)

Name of Honoree ____

Please send an acknowledgment card to: (amount of gift will not be included)

Name _______________________________________ Address ____

City _______________________ State ________________ Zip ____________ Telephone _______________